

VA MENTAL HEALTH LIVED EXPERIENCE COMMUNITY OF PRACTICE

Language Statement

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INTRODUCTION

As VA employees we subscribe to and attempt to embody VA's ICARE values—Integrity, Compassion, Advocacy, Respect, and Excellence. The language we use in addressing or describing individuals with lived experience of mental health challenges – whether they are Veterans or fellow employees – must be consistent with the ICARE values and can make a big difference in these persons' recovery.

This statement addresses language, including body language, other non-verbal language as well as words that we use and how we can strive to optimize that language to improve experiences for Veterans and VA employees living with mental health challenges and to optimize care and recovery for Veterans.

Our goals are to raise awareness of the importance of language and encourage new ways of speaking and thinking that are empowering, inclusive, positive, and encouraging. This a living document.

Our goal is not to be instructive or directive but to present ideas that encourage mindful interactions toward the most positive outcomes possible for all involved.

We encourage you to approach every person and every case individually.

PRINCIPLES

- Understand that there are negative and positive ways that language can have an impact on our outcomes.
- Use person-first language unless your client prefers otherwise.
- Focus on the person's strengths, not the illness.
- Use recovery language that is also empowering.
- Beware of using labels to describe individuals in conversations and notes.
- Use accepted clinical terminology to describe illnesses or symptoms; do not use derogatory terms to describe individuals. Words like "crazy," "looney," "insane," "psycho," "schizo," etc. are unacceptable when used as adjectives to describe an individual, and many people with lived experience of mental illness find these terms hurtful in any context.
- Don't make assumptions based solely on notes in the electronic health record (EHR).
- Avoid making judgmental statements in your conversations and EHR notes.
- Be mindful to avoid personal bias and preferences.
- Be mindful of unintended consequences when expressing your own personal opinions.
- Apply ethical and fundamental principles of holistic wellness in all you do.
- Remember the saying, "Nothing about me without me," and always seek to include relevant stakeholders in decisions.
- Have an "adult to adult" conversation – treat each person with respect.
- Each person has a right to self-determination – trust the Veteran's decision-making process, collaborate with them, and respect their decisions.
- Maintain awareness of your attitude, body language and surroundings.
- The use of active listening speaks volumes to your client.

CONCLUSION

We are guided by the VA mission, “To fulfill President Lincoln’s promise ‘To care for him who shall have borne the battle, and for his widow, and his orphan’ by serving and honoring the men and women who are America’s Veterans” (https://www.va.gov/about_va/mission.asp). As stated in the blog VAntage Point (<https://blogs.va.gov/VAntage/51197/vas-mission-americas-promise/>):

President Lincoln articulated for the nation a basic truth: that those who have made the greatest sacrifices in service to their country deserve their country’s service in return. And as our nation’s Veterans know all too well, service requires action.

Fulfilling the promise that President Lincoln made on behalf of the country is the mission of VA. It’s also the chosen responsibility of the physicians, nurses, allied health and other health care professionals who work every day to honor the service of our Veterans by caring for them with compassion, dedication and exceptional skill.

While language is a fundamental component of any human interaction, it is also powerful. Language can hurt. Language can connect. Language can heal. It is our duty and passion as VA employees to strive to use language to understand, connect with, and help our Veteran clients and fellow employees

USE OF LANGUAGE EXAMPLES

Medical Charts

Less Helpful Language

Robert is a 56-year-old patient with schizoaffective disorder, including a pattern of multiple episodes of inpatient care for mania. He is remarkably high-functioning for someone with schizoaffective disorder in that he has completed graduate study and works full-time. He reports that he has recently been calling in sick to work at high frequency due to insomnia and would medications to address insomnia. He has been non-compliant with medical recommendations for colonoscopy screening. I have changed his Depakote dose to [xx] to address his sleep concern.

Recovery Oriented Language

Robert is a 56-year-old Veteran who has been managing diagnosed schizoaffective disorder since age 24. He sought assistance from his psychiatry prescriber today because he has been having difficulty sleeping; he is aware that in the past insomnia has preceded hypomanic or manic episodes, and wishes to be proactive about preventing an episode.

Robert used inpatient care for two manic episodes at age 26 and age 30; since then he has been successful in managing his symptoms using only outpatient care. His episodes of inpatient care both occurred while he was pursuing undergraduate and graduate studies, and he eventually graduated with a master’s degree and works as a research coordinator. He is concerned because he has missed three days of work in the past two weeks due to poor sleep, which is very different from his usual pattern of work attendance.

On review of records, it is noted that Robert has not completed colon cancer screening; he reports that as a survivor of child sexual abuse he fears that colonoscopy may trigger a mood episode.

We discussed appropriate changes in dose for his Depakote to address his sleep. We discussed fecal screening for colon cancer; the Veteran was open to this idea and I have initiated a discussion with his primary care physician on this matter. The Veteran agrees to call back within the week to report on his sleep pattern so we can pursue further treatment plan changes as needed.

Informal, Verbal, Professional Consultation

Less Helpful Language

Lisa's religious delusions are driving me crazy. It seems that every intervention I make is useless because she keeps telling me that I'm violating her religious beliefs. She seems determined to be uncooperative with every aspect of her treatment; she won't agree to keep herself safe, she is refusing medications, she won't go to groups on the ward, and I don't know if we will ever be able to get her discharged from inpatient care.

Recovery Oriented Language

I'd like some consultation about engaging Lisa more meaningfully in treatment. She has some unusual religious beliefs that she believes are helping her to cope, and at the same time, many of these beliefs are barriers to treatment. She places these beliefs above her own safety, and states that G-d does not want her to take medications or participate in group psychotherapies. I would like to develop collaboration between her and the team on ways to keep her safe and move her to a less restrictive level of care.

Casual Conversation in the Community

Less Helpful Language

My mother-in-law is borderline, and nothing I do makes her happy. She asks us to visit, and then she complains about everything I do throughout the visit. She screams at me in front of our children, and they hate going to visit grandma. My spouse is doggedly attached to her, but I am going to have to give that side of my family an ultimatum.

Recovery Oriented Language

My mother-in-law manages very strong emotions, and I feel that she is unhappy with everything I do, even when I think I am doing exactly what she said she wants me to do. She is clearly having a lot of emotional pain that gets expressed through inappropriate screaming, even in front of children. I am concerned, both that this behavior is hurtful to me and to my children, and that it impairs her ability to maintain supportive relationships. My spouse and I need to negotiate new boundaries with her to support everyone in the family better.

Treatment Team Meetings

Less Helpful Language

Provider 1: Susan saw the vocational rehabilitation counselor today and doggedly insists that she wants to become a social worker, rather than seeking work that is more realistic for someone who is a frequent flyer in our inpatient unit. (Other providers on the team laugh.) We need to come together as a team to help her set more reasonable goals.

Provider 2: I think that we need to be clear with her than anyone who has a serious mental illness should not become a mental health care provider and help her explore other options.

Recovery Oriented Language

Provider 1: Susan is advocating for herself with the Vocational Rehabilitation System to approve an education plan for a master's degree in social work. Vocational Rehabilitation is resisting, pointing to her two admissions to inpatient care this year. I am concerned because Vocational Rehabilitation hasn't noted that she has been off of medication due to a pregnancy for the past six months, and this is the reason for her admissions. Until this year, she has not used inpatient care for five years. Vocational Rehabilitation has also failed to note that she is fluent in three languages and held advanced rank in the military. How can we support her self-advocacy?

Provider 2: Perhaps in this case we might do more than support self-advocacy. Sometimes our Vocational Rehabilitation providers dismiss self-report among clients who have used inpatient psychiatric care. Have you told them about the parts of her vocational history they are missing? If not, perhaps we should reach out to them.